Attachment 16.

Form Approved

OMB No. 0923-XXXX

Exp. Date xx/xx/201x xx/xx/20xxExDaxx/xx/20xx

Exp. Date xx/xx/20xx

**Multi-site Study Adult Questionnaire**

ATSDR estimates the average public reporting burden for this collection of information as 30 minutes per response, including the time for reviewing instructions, searching existing data/information sources, gathering and maintaining the data/information needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB Control Number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0923-xxxx).

Parent Study ID No. |*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*| (alias, if applicable)

Adult Study ID No. |*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*|

Section A: Demographic Information

A1. What is your age in years?

\_\_\_ years

\_\_\_Refused to answer

A2. What is your sex:

\_\_\_Male

\_\_\_Female

\_\_\_Refused to answer

A3. Do you consider yourself to be Hispanic or Latino?

\_\_\_Yes

\_\_\_No

\_\_\_Refused to answer

A4. What race do you consider yourself to be? Mark all that apply.

\_\_\_American Indian or Alaska Native

\_\_\_Asian

\_\_\_Black or African American

\_\_\_Native Hawaiian or Other Pacific Islander

\_\_\_White

\_\_\_Refused to answer

A5. What is the highest level of education you completed?

\_\_\_Less than high school

\_\_\_Some high school

\_\_\_High school graduate or equivalent (GED)

\_\_\_Some university/college

\_\_\_Technical or trade school

\_\_\_University/college graduate

\_\_\_Graduate school or higher

A6. What is your household income (from all sources)?

\_\_\_Less than $25,000

\_\_\_$25,000 to $69,000

\_\_\_$70,000 to $149,000

\_\_\_More than $150,000

\_\_\_Don’t know

\_\_\_Refused to answer

A7. During the last 12 months did you have any kind of health insurance?

\_\_\_Yes

\_\_\_No

\_\_\_Don’t know

\_\_\_Refused

**Section B: Residential History and Drinking Water Exposures**

B1. What is the main source of tap water in your home?

\_\_\_\_Public water system

\_\_\_\_Private well

\_\_\_\_Other: specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Don’t know

\_\_\_\_Refused to answer

B2. On average, how many 8 oz. cups of tap water or beverages prepared with tap water do you currently drink per day at home?

\_\_\_ cups

\_\_\_Don’t drink tap water

\_\_\_Don’t know

\_\_\_Refused to answer

Note: 1 cup = 8 oz.; 2 cups = 1 pint (16 oz.); 4 cups = 1 quart (32 oz.); 16 cups = 1 Gallon (128 oz.)

B3. What was your previous address?

Street Apt

City State \_\_ \_\_ Zip Code:

B4. When did you move into your previous address? Month\_\_\_\_ Year\_\_\_\_\_\_\_

B5. What was the main source of tap water at that address?

\_\_\_\_Public water system

\_\_\_\_Private well

\_\_\_\_Other: specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Don’t know

\_\_\_\_Refused to answer

B6. On average, how many 8 oz. cups of tap water or beverages prepared with tap water did you drink per day when you lived at that address?

\_\_\_ cups

\_\_\_Don’t drink tap water

\_\_\_Don’t know

\_\_\_Refused to answer

Note: 1 cup = 8 oz.; 2 cups = 1 pint (16 oz.); 4 cups = 1 quart (32 oz.); 16 cups = 1 Gallon (128 oz.)

B7. Have you lived at any other address since January 2000?

\_\_\_ Yes

\_\_\_No → go to Section C

\_\_\_Don’t know → go to Section C

\_\_\_Refused to answer → go to Section C

B8. Please fill out the table below for these other residences where you lived since January 2000.

|  |  |  |  |
| --- | --- | --- | --- |
| Street Address, City, State | Move in (mm/yy) | Average consumption of tap water per day (# cups) | Main source of tap water at this address (public water system or private well?) |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Section C: History of Potential Exposure Modifiers**

C1. Have you ever had a blood transfusion?

\_\_\_Yes → Please specify how many times you had a blood transfusion\_\_\_\_\_\_\_\_\_\_

\_\_\_No →go to Question C3

\_\_\_Don’t know →go to Question C3

\_\_\_Refused to answer →go to Question C3

C2. When did you last have a blood transfusion?

\_\_\_\_\_\_\_\_month/year

C3. Have you ever donated blood?

\_\_\_Yes→ Please specify how many times you have donated blood\_\_\_\_\_\_\_\_\_\_

\_\_\_No →go to Question D1

\_\_\_Don’t know →go to Question D1

\_\_\_Refused to answer →go to Question D1

C4. When did you last donate blood?

\_\_\_\_\_\_\_\_ Month/Year

C5. On average, how often do you donate blood in a year?

\_\_\_\_\_\_\_\_\_\_

**Section D: Occupational History**

D1. What is your primary occupation?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

D2. On average, how many 8 oz. cups of tap water or beverages prepared with tap water do you currently drink per day at work?

\_\_\_ cups

\_\_\_Don’t drink tap water

\_\_\_Don’t know

\_\_\_Refused to answer

Note: 1 cup = 8 oz.; 2 cups = 1 pint (16 oz.); 4 cups = 1 quart (32 oz.); 16 cups = 1 Gallon (128 oz.)

D3. Please fill out the table below for each job that lasted one month or more starting from the present and working back to 2000.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Job information | Job 1 | Job 2 | Job 3 | Job 4 |
| a. Where did you work (City, State) |  |  |  |  |
| b. Name of the employer |  |  |  |  |
| c. Start date (month, year) |  |  |  |  |
| d. End date (month, year) |  |  |  |  |
| e. Job title/description |  |  |  |  |
| f. Did you work as a firefighter?  If you worked as a firefighter, did you come into contact with firefighting foam used for fires that involve flammable liquids (also known as Class B fires)? | Yes\_\_\_  No\_\_\_\_ go to question g.  Yes\_\_\_\_  No\_\_\_\_  Don’t know\_\_\_\_ | Yes\_\_\_  No\_\_\_\_ go to question g.  Yes\_\_\_\_  No\_\_\_\_  Don’t know\_\_\_\_ | Yes\_\_\_  No\_\_\_\_ go to question g.  Yes\_\_\_\_  No\_\_\_\_  Don’t know\_\_\_\_ | Yes\_\_\_  No\_\_\_\_ go to question g.  Yes\_\_\_\_  No\_\_\_\_  Don’t know\_\_\_\_ |
| g. Was this job in any of the following industries? | Manufacturing of nonstick cookware  \_\_\_\_yes \_\_\_\_no  Manufacturing of stain resistant coatings used on carpets, upholstery, and other fabrics  \_\_\_\_\_yes \_\_\_\_no  Manufacturing of water resistant clothing  \_\_\_\_\_yes \_\_\_\_no | Manufacturing of nonstick cookware  \_\_\_\_yes \_\_\_\_no  Manufacturing of stain resistant coatings used on carpets, upholstery, and other fabrics  \_\_\_\_\_yes \_\_\_\_no  Manufacturing of water resistant clothing  \_\_\_\_\_yes \_\_\_\_no | Manufacturing of nonstick cookware  \_\_\_\_yes \_\_\_\_no  Manufacturing of stain resistant coatings used on carpets, upholstery, and other fabrics  \_\_\_\_\_yes \_\_\_\_no  Manufacturing of water resistant clothing  \_\_\_\_\_yes \_\_\_\_no | Manufacturing of nonstick cookware  \_\_\_\_yes \_\_\_\_no  Manufacturing of stain resistant coatings used on carpets, upholstery, and other fabrics  \_\_\_\_\_yes \_\_\_\_no  Manufacturing of water resistant clothing  \_\_\_\_\_yes \_\_\_\_no |
| h. Did you work with or around any chemicals at this job such as solvents, metals, asbestos, or pesticides? | Yes (Please specify the chemical) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No \_\_\_\_  Don’t know\_\_\_ | Yes (Please  specify the chemical) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No\_\_\_  D DDon’t know\_\_\_ | Yes (Please  specify the chemical) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No\_\_\_\_  Don’t know\_\_\_\_ | Yes (Please specify the chemical) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No\_\_\_\_  Don’t know\_\_\_\_ |
| i. Did you work with radiation? | Yes\_\_\_  No\_\_\_\_ | Yes\_\_\_  No\_\_\_\_ | Yes\_\_\_  No\_\_\_\_ | Yes\_\_\_  No\_\_\_\_ |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Job information | Job 5 | Job 6 | Job 7 | Job 8 |
| a. Where did you work (City, State) |  |  |  |  |
| b. Name of the employer |  |  |  |  |
| c. Start date (month, year) |  |  |  |  |
| d. End date (month, year) |  |  |  |  |
| e. Job title/description |  |  |  |  |
| f. Did you work as a firefighter?  If you worked as a firefighter, did you come into contact with firefighting foam used for fires that involve flammable liquids (also known as Class B fires)? | Yes\_\_\_  No\_\_\_\_ go to question g.  Yes\_\_\_\_  No\_\_\_\_  Don’t know\_\_\_\_ | Yes\_\_\_  No\_\_\_\_ go to question g.  Yes\_\_\_\_  No\_\_\_\_  Don’t know\_\_\_\_ | Yes\_\_\_  No\_\_\_\_ go to question g.  Yes\_\_\_\_  No\_\_\_\_  Don’t know\_\_\_\_ | Yes\_\_\_  No\_\_\_\_ go to question g.  Yes\_\_\_\_  No\_\_\_\_  Don’t know\_\_\_\_ |
| g. Was this job in any of the following industries? | Manufacturing of nonstick cookware  \_\_\_\_yes \_\_\_\_no  Manufacturing of stain resistant coatings used on carpets, upholstery, and other fabrics  \_\_\_\_\_yes \_\_\_\_no  Manufacturing of water resistant clothing  \_\_\_\_\_yes \_\_\_\_no | Manufacturing of nonstick cookware  \_\_\_\_yes \_\_\_\_no  Manufacturing of stain resistant coatings used on carpets, upholstery, and other fabrics  \_\_\_\_\_yes \_\_\_\_no  Manufacturing of water resistant clothing  \_\_\_\_\_yes \_\_\_\_no | Manufacturing of nonstick cookware  \_\_\_\_yes \_\_\_\_no  Manufacturing of stain resistant coatings used on carpets, upholstery, and other fabrics  \_\_\_\_\_yes \_\_\_\_no  Manufacturing of water resistant clothing  \_\_\_\_\_yes \_\_\_\_no | Manufacturing of nonstick cookware  \_\_\_\_yes \_\_\_\_no  Manufacturing of stain resistant coatings used on carpets, upholstery, and other fabrics  \_\_\_\_\_yes \_\_\_\_no  Manufacturing of water resistant clothing  \_\_\_\_\_yes \_\_\_\_no |
| h. Did you work with or around any chemicals at this job such as solvents, metals, asbestos, or pesticides? | Yes (Please specify the chemical) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No \_\_\_\_  Don’t know\_\_\_ | Yes (Please  specify the chemical) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No\_\_\_  D DDon’t know\_\_\_ | Yes (Please  specify the chemical) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No\_\_\_\_  Don’t know\_\_\_\_ | Yes (Please specify the chemical) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No\_\_\_\_  Don’t know\_\_\_\_ |
| i. Did you work with radiation? | Yes\_\_\_  No\_\_\_\_ | Yes\_\_\_  No\_\_\_\_ | Yes\_\_\_  No\_\_\_\_ | Yes\_\_\_  No\_\_\_\_ |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Job information | Job 9 | Job 10 | Job 11 | Job 12 |
| a. Where did you work (City, State) |  |  |  |  |
| b. Name of the employer |  |  |  |  |
| c. Start date (month, year) |  |  |  |  |
| d. End date (month, year) |  |  |  |  |
| e. Job title/description |  |  |  |  |
| f. Did you work as a firefighter?  If you worked as a firefighter, did you come into contact with firefighting foam used for fires that involve flammable liquids (also known as Class B fires)? | Yes\_\_\_  No\_\_\_\_ go to question g.  Yes\_\_\_\_  No\_\_\_\_  Don’t know\_\_\_\_ | Yes\_\_\_  No\_\_\_\_ go to question g.  Yes\_\_\_\_  No\_\_\_\_  Don’t know\_\_\_\_ | Yes\_\_\_  No\_\_\_\_ go to question g.  Yes\_\_\_\_  No\_\_\_\_  Don’t know\_\_\_\_ | Yes\_\_\_  No\_\_\_\_ go to question g.  Yes\_\_\_\_  No\_\_\_\_  Don’t know\_\_\_\_ |
| g. Was this job in any of the following industries? | Manufacturing of nonstick cookware  \_\_\_\_yes \_\_\_\_no  Manufacturing of stain resistant coatings used on carpets, upholstery, and other fabrics  \_\_\_\_\_yes \_\_\_\_no  Manufacturing of water resistant clothing  \_\_\_\_\_yes \_\_\_\_no | Manufacturing of nonstick cookware  \_\_\_\_yes \_\_\_\_no  Manufacturing of stain resistant coatings used on carpets, upholstery, and other fabrics  \_\_\_\_\_yes \_\_\_\_no  Manufacturing of water resistant clothing  \_\_\_\_\_yes \_\_\_\_no | Manufacturing of nonstick cookware  \_\_\_\_yes \_\_\_\_no  Manufacturing of stain resistant coatings used on carpets, upholstery, and other fabrics  \_\_\_\_\_yes \_\_\_\_no  Manufacturing of water resistant clothing  \_\_\_\_\_yes \_\_\_\_no | Manufacturing of nonstick cookware  \_\_\_\_yes \_\_\_\_no  Manufacturing of stain resistant coatings used on carpets, upholstery, and other fabrics  \_\_\_\_\_yes \_\_\_\_no  Manufacturing of water resistant clothing  \_\_\_\_\_yes \_\_\_\_no |
| h. Did you work with or around any chemicals at this job such as solvents, metals, asbestos, or pesticides? | Yes (Please specify the chemical) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No \_\_\_\_  Don’t know\_\_\_ | Yes (Please  specify the chemical) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No\_\_\_  D DDon’t know\_\_\_ | Yes (Please  specify the chemical) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No\_\_\_\_  Don’t know\_\_\_\_ | Yes (Please specify the chemical) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No\_\_\_\_  Don’t know\_\_\_\_ |
| i. Did you work with radiation? | Yes\_\_\_  No\_\_\_\_ | Yes\_\_\_  No\_\_\_\_ | Yes\_\_\_  No\_\_\_\_ | Yes\_\_\_  No\_\_\_\_ |

**Section E: Medical History**

E1. Have you ever been told by a doctor or other health care provider that you have or had any of the following medical conditions? If yes, we may request access to your medical records. Fill out the table below. Circle appropriate response and ask the respondent to specify as directed.

| Medical condition |  | If yes, what year were you diagnosed? |
| --- | --- | --- |
| 1. Thyroid disease? | Yes (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Don’t know | \_ \_ \_ \_ year |
| 1. High cholesterol? | Yes  No  Don’t know | \_ \_ \_ \_ year |
| 1. High blood pressure? (not including pregnancy induced hypertension) | Yes  No  Don’t know | \_ \_ \_ \_ year |
| 1. Heart Disease? | Yes  No  Don’t know | \_ \_ \_ \_ year |
| 1. Osteoarthritiss? | Yes  No  Don’t know | \_ \_ \_ \_ year |
| 1. Osteoporosis | Yes  No  Don’t know | \_ \_ \_ \_ year |
| 1. Endometriosis? | Yes  No  Don’t know | \_ \_ \_ \_ year |
| 1. Liver disease? | Yes (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Don’t know | \_ \_ \_ \_ year |
| 1. Kidney disease? | Yes (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Don’t know | \_ \_ \_ \_ year |
| 1. Ulcerative colitis? | Yes  No  Don’t know | \_ \_ \_ \_ year |
| 1. Rheumatoid arthritis? | Yes  No  Don’t know | \_ \_ \_ \_ year |
| 1. Lupus? | Yes  No  Don’t know | \_ \_ \_ \_ year |
| 1. Multiple sclerosis? | Yes  No  Don’t know | \_ \_ \_ \_ year |
| 1. Diabetes (not related to pregnancy)? | Yes (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Don’t know | \_ \_ \_ \_ year |
| 1. Asthma | Yes  No  Don’t know | \_ \_ \_ \_ year |
| 1. Parkinson Disease | Yes  No  Don’t know | \_ \_ \_ \_ year |
| 1. Chronic bronchitis | Yes  No  Don’t know | \_ \_ \_ \_ year |
| 1. Emphysema | Yes  No  Don’t know | \_ \_ \_ \_ year |
| 1. Fibromyalgia | Yes  No  Don’t know | \_ \_ \_ \_ year |
| 1. Celiac Disease | Yes  No  Don’t know | \_ \_ \_ \_ year |
| 1. Crohn’s Disease | Yes  No  Don’t know | \_ \_ \_ \_ year |
| 1. Scleroderma? | Yes  No  Don’t know | \_ \_ \_ \_ year |
| 1. Atopic dermatitis/eczema? | Yes (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Don’t know | \_ \_ \_ \_ year |
| 1. Allergies? | Yes (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Don’t know | \_ \_ \_ \_ year |
| 1. Infertility? | Yes  No  Don’t know | \_ \_ \_ \_ year |

E2. Have you ever been told by a doctor or other health care provider that you have or had a cancer?

\_\_\_\_Yes, please specify the cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_No → go to Question F1 if male; go to Question E7 if female

\_\_\_\_Don’t know → go to Question F1 if male; go to Question E7 if female

E3. In what state were you diagnosed with the cancer and when were you diagnosed?

\_\_\_\_\_\_\_\_State where you were diagnosed

\_\_\_\_\_\_\_Year you were diagnosed

E4. Have you been diagnosed with another cancer?

\_\_\_\_Yes, please specify the cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_No → go to Question F1 if male; go to Question E7 if female

E5. In what state were you diagnosed with the other cancer and when were you diagnosed?

\_\_\_\_\_\_\_\_State where you were diagnosed

\_\_\_\_\_\_\_Year you were diagnosed

E6. Please list any additional cancer that you were diagnosed with, the year that you were diagnosed, and the state where you were diagnosed:

\_\_\_\_\_\_\_\_\_\_Type of cancer \_\_\_\_\_\_\_\_\_\_\_\_Type of cancer

\_\_\_\_\_\_\_\_\_\_Year diagnosed \_\_\_\_\_\_\_\_\_\_\_Year diagnosed

\_\_\_\_\_\_\_\_\_\_State where you were diagnosed \_\_\_\_\_\_\_\_\_\_State where you were diagnosed

**FOR WOMEN ONLY**

E7. Have you ever used an oral contraceptive (“birth control pill”)?

\_\_\_Yes

\_\_\_No → go to Question E9

\_\_\_Don’t know → go to Question E9

\_\_\_Refused to answer → go to Question E9

E8. When did you last use an oral contraceptive (“birth control pill”)?

\_\_\_\_\_\_\_\_ Month/Year

E9. At what age did you begin menstruation (have your first period)?

\_\_\_Age when you began menstruation

\_\_\_Never menstruated → go to Section F

\_\_\_Don’t know

E10. Does your period occur regularly (every month)?

\_\_\_Yes → go to Question E13

\_\_\_No, it is irregular → go to Question E13

\_\_\_No, I don’t have a period

\_\_\_Don’t know → go to Question E13

E11. Why did your periods stop?

\_\_\_Pregnant

\_\_\_Menopausal

\_\_\_Had hysterectomy

\_\_\_Don’t know

E12. What age was your last period?

\_\_\_ years

\_\_\_Don’t know

E12a. During the period when you had periods, what was your usual period flow?

\_\_\_Light→ go to Question 16

\_\_\_Medium→ go to Question 16

\_\_\_Heavy→ go to Question 16

\_\_\_Don’t know→ go to Question 16

E13. When was your last period before this study blood draw?

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Don’t know

E14. How many days has been your cycle on average during the last year?

\_\_\_>26 days

\_\_\_27-29 days

\_\_\_30-32

\_\_\_>32 days

\_\_\_Don’t know

E15. Can you characterize your usual period flow during the last year?

\_\_\_Light

\_\_\_Medium

\_\_\_Heavy

\_\_\_Don’t know

E16. Have you ever been pregnant?

\_\_\_Yes

\_\_\_No → go to Section F

\_\_\_Don’t know

E17. How many times have you been pregnant in your life?

\_\_\_\_\_\_\_ times

E18. Now I’d like to get more information about each of your pregnancies. Let’s start with your most recent pregnancy.Fill out the table below. Circle appropriate response and ask the respondent to specify as directed.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Pregnancy 1** | **Pregnancy 2** | **Pregnancy 3** | **Pregnancy 4** |
| a. What month and year did this pregnancy start? | **\_ \_ / \_ \_ \_ \_** | **\_ \_ / \_ \_ \_ \_** | **\_ \_ / \_ \_ \_ \_** | **\_ \_ / \_ \_ \_ \_** |
| b. What month and year did this pregnancy end? | **\_ \_ / \_ \_ \_ \_** | **\_ \_ / \_ \_ \_ \_** | **\_ \_ / \_ \_ \_ \_** | **\_ \_ / \_ \_ \_ \_** |
| c. Did the pregnancy result in a live birth? | Yes  No (go to g)  Don’t Know | Yes  No (go to g)  Don’t Know | Yes  No (go to g)  Don’t Know | Yes  No (go to g)  Don’t Know |
| d. Did you breastfed this child/these children? | Yes  No → go to k.  Don’t know | Yes  No → go to k.  Don’t know | Yes  No → go to k.  Don’t know | Yes  No → go to k.  Don’t know |
| e. How long did you breastfeed [this child/these children]? | \_\_ months | \_\_ months | \_\_ months | \_\_ months |
| f. When did you stop breastfeeding this child/these children? | \_\_month \_\_\_\_ year | \_\_month \_\_\_\_ year | \_\_month \_\_\_\_ year | \_\_month \_\_\_\_ year |
| g. Did a doctor or nurse say that you had pre-eclampsia during your  pregnancy? | Yes  No  Don’t know | Yes  No  Don’t know | Yes  No  Don’t know | Yes  No  Don’t know |
| h. Did a doctor or nurse say that you had pregnancy-induced hypertension? | Yes  No  Don’t know | Yes  No  Don’t know | Yes  No  Don’t know | Yes  No  Don’t know |
| i. Did a doctor or nurse say that you had gestational diabetes? | Yes  No  Don’t know | Yes  No  Don’t know | Yes  No  Don’t know | Yes  No  Don’t know |

**Section F: Social History**

The following questions ask about smoking and alcohol use.

F1. Have you ever smoked cigarettes?

\_\_\_Yes

\_\_\_No → go to Question F7

F2. Do you currently smoke cigarettes?

\_\_\_Yes

\_\_\_No → go to Question F5

F3. On average, how many cigarettes do you smoke a day? 1 pack = 20 cigarettes. Enter ‘00’ if less than 1 cigarette per day.

\_\_\_\_\_ cigarettes per day

F4. In total, how many years have you smoked, excluding any times you may have quit? Enter ‘00’ if less than 1 year.

\_\_\_\_ years → go to Question F7

F5. How many years did you smoke before you quit?

\_\_\_years

\_\_\_ Don’t know

F5a. How long ago did you quit?

\_\_\_Less than 5 years ago

\_\_\_5-9 years ago

\_\_\_More than 10 years ago

\_\_\_Don’t know

F6. On average, when you were smoking, about how many cigarettes per day did you smoke? 1 pack = 20 cigarettes. Enter ‘00’ if less than 1 cigarette per day.

\_\_\_\_\_ cigarettes per day

F7. Have you ever used any other tobacco products (such as chewing tobacco, smokeless tobacco, cigars, a pipe, etc.)?

\_\_\_Yes

\_\_\_No → go to Question F10

F8. Do you currently use any of these tobacco products?

\_\_\_Yes

\_\_\_No

F9. Have you ever drunk alcoholic beverages? (This includes beer, wine, wine coolers, hard

lemonade, and spirits.)

\_\_\_Yes

\_\_\_No → go to Section G

F10. Do you currently drink alcoholic beverages? (This includes beer, wine, wine coolers, hard lemonade, and spirits.)

\_\_\_Yes

\_\_\_No → go to Section G.

F11. On average, how often do you drink alcoholic beverages?

\_\_\_Every day or almost every day

\_\_\_2 to 4 times a week

\_\_\_1 time a week

\_\_\_1 to 3 times a month

\_\_\_Less than once a month

F12. When you drink, how many servings of alcohol do you usually have? One “serving” equals any of the following: 1 can of beer, 1 glass of wine, 1 can or bottle of wine cooler, or 1 shot of liquor.

\_\_\_ servings

F13. In total, how many years have you drank, excluding any times you may have quit? Enter ‘00’ if less than 1 year.

\_\_\_\_ years → go to Section G

F14. When you were consuming alcoholic beverages, how often did you drink on average?

\_\_\_Every day or almost every day

\_\_\_2 to 4 times a week

\_\_\_1 time a week

\_\_\_1 to 3 times a month

\_\_\_Less than once a month

F15. When you drank, how many servings of alcohol did you usually have? One “serving” equals any of the following: 1 can of beer, 1 glass of wine, 1 can or bottle of wine cooler, or 1 shot of liquor.

\_\_\_ servings

F16. In total, how many years did you drink? Enter ‘00’ if less than 1 year.

\_\_\_\_ years

F17. How long ago did you quit?

\_\_\_Less than 5 years ago

\_\_\_More than 5 years ago

\_\_\_Don’t know

**Section G: Family Medical History**

G1. Do any of your blood relatives - children, parents, or siblings - currently have cancer or have they had cancer? We are only asking about family members who are blood relatives: children, parents, and siblings.

\_\_\_Yes

\_\_\_No → go to Question G4

G2. In all, how many family members (not including yourself) have had (or now have) cancer?

**\_\_\_**number

\_\_\_Don’t know

G3. Now I’d like to get more information about each of your relatives who had/has cancer. Fill out the table below. Circle appropriate response and ask the respondent to specify as directed. Complete the information for the first relative completely before asking about the next relative. Once information about all blood relatives with cancer has been collected, go to Question G4.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **First relative** | **Second relative** | **Third relative** | **Fourth relative** |
| a. Was this relative a . . . | Child  Parent  Sibling | Child  Parent  Sibling | Child  Parent  Sibling | Child  Parent  Sibling |
| b. What type of cancer did this relative have |  |  |  |  |
| c. Is this relative | Living  Deceased | Living  Deceased | Living  Deceased | Living  Deceased |
| d. What year was your relative diagnosed with cancer? | \_ \_ \_ \_  Don’t know | \_ \_ \_ \_  Don’t know | \_ \_ \_ \_  Don’t know | \_ \_ \_ \_  Don’t know |

G4. Have any of your blood relatives (that is children, parents, or siblings) ever been told by a health professional that they have or had any of the following conditions? Fill out the table below. Circle appropriate response and ask the respondent to specify as directed.

|  |  |  |
| --- | --- | --- |
| Medical condition |  | If yes, ask: Which relative had this condition? |
| 1. Thyroid disease? | Yes (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Don’t know | Child  Parent  Sibling |
| 1. High cholesterol? | Yes  No  Don’t know | Child  Parent  Sibling |
| 1. High blood pressure? (not including pregnancy induced hypertension) | Yes  No  Don’t know | Child  Parent  Sibling |
| 1. Heart Disease? | Yes  No  Don’t know | Child  Parent  Sibling |
| 1. Osteoarthritis? | Yes  No  Don’t know | Child  Parent  Sibling |
| 1. Osteoporosis? | Yes  No  Don’t know | Child  Parent  Sibling |
| 1. Endometriosis? | Yes  No  Don’t know | Child  Parent  Sibling |
| 1. Liver disease? | Yes (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Don’t know | Child  Parent  Sibling |
| 1. Kidney disease? | Yes (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Don’t know | Child  Parent  Sibling |
| 1. Ulcerative colitis? | Yes  No  Don’t know | Child  Parent  Sibling |
| 1. Rheumatoid arthritis? | Yes  No  Don’t know | Child  Parent  Sibling |
| 1. Lupus? | Yes  No  Don’t know | Child  Parent  Sibling |
| 1. Multiple sclerosis? | Yes  No  Don’t know | Child  Parent  Sibling |
| 1. Diabetes (not related to pregnancy)? | Yes (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Don’t know | Child  Parent  Sibling |
| 1. Asthma? | Yes  No  Don’t know | Child  Parent  Sibling |
| 1. Parkinson Disease? | Yes  No  Don’t know | Child  Parent  Sibling |
| 1. Chronic bronchitis? | Yes  No  Don’t know | Child  Parent  Sibling |
| 1. Emphysema? | Yes  No  Don’t know | Child  Parent  Sibling |
| 1. Fibromyalgia? | Yes  No  Don’t know | Child  Parent  Sibling |
| 1. Celiac Disease? | Yes  No  Don’t know | Child  Parent  Sibling |
| 1. Crohn’s Disease? | Yes  No  Don’t know | Child  Parent  Sibling |
| 1. Scleroderma? | Yes  No  Don’t know | Child  Parent  Sibling |
| 1. Atopic dermatitis/eczema? | Yes (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Don’t know | Child  Parent  Sibling |
| 1. Allergies? | Yes (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Don’t know | Child  Parent  Sibling |
| 1. Infertility? | Yes  No  Don’t know | Child  Parent  Sibling |

CONCLUSION: That completes this survey. I would like to sincerely thank you for your time.